STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013602	A. BUILDING: _____ B. WING _____	03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUNOVA HOME CARE LLC	6910 NORTH MAIN STREET, SUITE 23A GRANGER, IN 46530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This visit was for a Home Health initial State Licensure survey. Survey Dates: March 18 and 19, 2015 Facility #: 013602 Surveyor: Tonya Tucker, RN, PHNS Unduplicated Census: 5 Current Skilled Patients: 2 Current Physical Therapy patients: 1 Discharged Patients: 2 Home Visits: 2 AuNova Home Care LLC is in compliance with the Indiana rules for licensure 410 IAC Article 17. Quality Review: Joyce Elder, MSN, BSN, RN March 23, 2015	N 000		